2003 HUMAN BEHAVIOR COURSE BLOCK TWO CHALLENGES

4 QUESTIONS CHALLENGED
4 TOTAL CHALLENGES
NO CHANGES TO THE ANSWER KEY

Question 3.
Mrs. Found was involved in a minor automobile accident. She escaped with no physical injuries, and drifted off from the scene of the accident. A month later, a friend happened upon Mrs. Found working at a bowling alley in another town. Mrs. Found did not recognize her friend and didn't remember the accident, and told the friend that she couldn't remember anything before a couple of weeks ago. She couldn't remember her name, so she took the name of Mrs. Lost and got the job at the bowling alley. Mrs. Lost-Found is otherwise healthy. Which diagnosis is best?

A. Dissociative Identity Disorder
B. Depersonalization Disorder
C. Post-Traumatic Stress Disorder
D. **XX** Dissociative Fugue Disorder
E. Dissociative Amnesia

Challenge.

1. The question I am challenging addresses a female in a traumatic MVA who suffers from amnesia and wanders off to a new town and assumes a new life. While I can understand why "fugue" applies to this scenario, does it not stand to reason that had the female suffered from an amnestic disorder due to the trauma of the event, described in the text as a general/global loss of memory that can include identity, since she was on the road and not near home, she would have no choice but to wander (not knowing where home is and who she is) to a new town?

Dr. Engel Response. Correct answer is D. Page 320 of your book describes how one might should about the differential diagnosis in this case. "The memory disturbance of dissociative fugue may be similar to that of dissociative amnesia, but the latter does not involve purposeful travel or the assumption of a new personal identity. She didn't have to wander (she could have stayed with the car). One might argue that the movement to the new town may have been less than purposeful, but when combined with the assumption of the new identity, this story is fairly classical for dissociative fugue disorder. One could argue that perhaps there is little here to exclude dissociative identity disorder, but a classic DID story would involve much greater complexity than this (long term pattern of poor functioning, early childhood abuse, more than one 'alter', lots of odd associated symptoms like hearing voices of 'alters', mood problems, and somatization) and would be part of a chronic pattern rather than the acute onset described in this vignette. The BEST diagnosis (what the question asks for) is therefore dissociative fugue disorder.

Question 5.
A patient tells you that he was at work one day and suddenly had "an out of body experience". After clarifying the history, you decide that he has experienced depersonalization, the feeling of being an outside observer of one's own body. This symptom is associated with…

A. Normal adolescence
B. Major depressive disorder
C. Panic disorder
D. Depersonalization disorder
E. **XX** All of the above

Challenge.

1. #5 concerning the patient who had an "out of body experience." The correct answer was given as E "all of the above" While I agree that depersonalization can be an aspect of Major depressive disorder (if it includes an element of psychosis) and Panic disorder, my understanding is this is a very reare symptom of these 2 disorders. Also, I absolutely disagree that depersonalization is an aspect of normal adolescence. That seems completely ridiculous and in itself should invalidate E as an option. I actually discussed this question with a friend who is a practicing psychologist and he agreed with me that D (depersonalization disorder) should be the correct answer. He agreed that "out of body experiences" were not a normal part of adolescence and therefore disqualified E and that depersonalization was such an uncommon symptom of B and C that they weren't even really in the same league.

Dr. Engel Response. Correct answer is E. Your book (page 321) characterizes the depersonalization found in depersonalization disorder as “the occurrence of persistent or recurrent episodes of depersonalization”. Depersonalization as an isolated one-time symptom can be quite common and nonspecific. On page 322 your book states that, “Depersonalization is a very common psychiatric symptom and may be associated with depression, anxiety and panic disorders, psychosis, trauma disorders, personality disorders, delirium, and seizure disorders; it is common in normal adolescents.”

Question 14.

Which of the following may be the cause of Ms. Smith’s symptoms & signs?

A. Opioid narcotic
B. Anticholinergic medication
C. Benzodiazepine
D. Infection
E. **XX** All of the above

Challenge.

1. #14 I would like to challenge because the woman in the vignette is suffering from delirium which can be caused by withdrawal from many drugs but not the drugs themselves. I think the answers for A, B, and C if they wished them to be correct should have been withdrawal from any of those drugs.

Dr. Engel Response. Correct answer is E. Delirium MAY be caused by withdrawal from some drugs (CNS depressants such as alcohol, barbiturates, or benzodiazepines for example) but the perhaps most common cause of delirium on medical wards are iatrogenic and caused by medications such as medicines with anticholinergic effects (e.g., antihistamines, some antiemetics and antidepressants), opioid narcotics (street users of heroin often describe this delirium as “the nods”), or benzodiazepines and other CNS depressants including alcohol). Indeed, opioids and anticholinergics are not associated with withdrawal delirium per se. Please see also table 16-10 (page 201 in your book) for a nice short summary of the multiple factors that can cause delirium. You

should commit this table to memory.

Question 19.
Which of the following is true the woman in the last question?

A. Her risk of developing PTSD is the same as for a similarly assaulted but asymptomatic victim
B. Her chance of spontaneous recovery is small
C. **XX** Cognitive-behavioral therapy is an effective therapy
D. All of the above
E. None of the above

Challenge.

1. #19 concerning what is true regarding the woman who was "sexually assualted 10 days ago." For this question I answered E (None of the above) and the correct answer was given as C (cognitive-behavioral therapy). My understanding of cognitive-behavioral therapy is that it is based on the concept that a patient's thoughts are somehow "faulty" and it focuses on teaching a patient to identify the negative and "faulty" thoughts they are having and focus on eliminating them and increasing the positive thoughts. While I can see how this is important in treating normal depressed patients and this patient is probably severely depressed, I would argue that this situation is very different from normal depression. Showing her how to recognize how her thoughts are "faulty" does not seem to be the best approach, especially as in our notes it does not discuss using cognitive-behavioral therapy with ASD or PTSD but it does mention letting a patient know their reaction to the traumatice event is completely NORMAL (which seems almost the opposite of what this therapy does). Under these circumstances I would argue that E (none of the above) is a more appropriate answer.

Dr. Engel Response. Correct answer is C. The answer to this question is contained in slide 28 of Dr. Holloway's lecture on "Reactions to Stress & Trauma" (syllabus page 295). This slide notes that "cognitive-behavioral therapy [is] successful in clinical trials". Cognitive distortions are common in normal and abnormal states (e.g., as was noted in the lecture on behavioral and cognitive therapies, cognitive psychology has also been used to reduce errors that physicians make in clinical practice). In fact, telling someone that their reaction is normal is easily viewed through a cognitive theoretical lens: in the acute aftermath of trauma, the victim is likely to hold any number of 'distortions' regarding their current status. For example, the victim may conclude her life has been ruined forever, that she is going "crazy", or that she is somehow at fault for the event. The most basic cognitive intervention is therefore dissemination of information that helps her put those notions into a more balanced and ultimately more optimistic perspective. A full course of cognitive therapy would involve a more intensive process whereby the therapist aligns herself with the patient and helps the patient to test, for example, that she is the one to blame for the rape.